

**Medical Increase Worksheet – ICF/IID Only
(Nursing Services Provided > 180 Minutes Per Week)**

Name of Individual	Age	No. of Nursing Minutes Per Week
Name of Facility	Comp. Code	Contract No.
Name of Nurse Completing This Form	Title	
Area Code and Telephone No.	Date Completed	

List the medical condition(s) requiring nursing intervention:

List the treatment the individual receives:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> tube feeding(s) | <input type="checkbox"/> accuchecks | <input type="checkbox"/> colostomy care | <input type="checkbox"/> tracheostomy care |
| <input type="checkbox"/> chronic decubitus care | <input type="checkbox"/> routine medication administration | <input type="checkbox"/> ureterostomy care | <input type="checkbox"/> routine chronic treatments |
| <input type="checkbox"/> prosthesis care | <input type="checkbox"/> seizure monitoring | <input type="checkbox"/> resides in the infirmary | |
| <input type="checkbox"/> SAM teaching/monitoring | <input type="checkbox"/> other: _____ | | |

List other contributing factors for the individual's medical condition:

Are services provided by (check one or both if applicable): RNs LVNs

Task	Frequency	Minutes Per Day

How were the above minutes determined? _____

The following documentation should be included in the LON medical increase packet. Check all the items attached:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ICAP booklet/scoring sheet | <input type="checkbox"/> nurses' narrative notes | <input type="checkbox"/> nursing assessments | <input type="checkbox"/> physician assessments |
| <input type="checkbox"/> physician orders | <input type="checkbox"/> staffing summaries | <input type="checkbox"/> current medication treatment sheets | |
| <input type="checkbox"/> other: _____ | | | |